Table of Contents

Title 40
LABOR AND EMPLOYMENT

Part I. Workers' Compensation Administration

Title 40

LABOR AND EMPLOYMENT

Part I. Worker's Compensation Administration

Chapter 27. Utilization Review Procedures

§ 2701. Statement Of Policy

A. It is the intent of this rule to establish procedures and policies appropriate to the fulfillment of the powers, duties, and functions of the Director of the Office of Workers' Compensation as set forth in RS 23:1291 (Act 938 of the 1988 Regular Session). R.S. 23:1291 empowers the Director of the Office of Workers' Compensation.

1. "to resolve disputes over the necessity, advisability, and cost of proposed or already performed hospital care or services, medical or surgical treatment, or any nonmedical treatment recognized by the laws of this state as legal."

. . . and . . .

2. "to audit the specific medical records of the patient under treatment by any health care provider who has furnished services or treatment to a person covered by this Chapter, or the records of any person or entity rendering care, services, or treatment or furnishing drugs or supplies for the purpose of determining whether an inappropriate reimbursement has been made."

B. The law provides that an employer or compensation insurer owes to an injured worker one hundred percent of the medical fees incurred in the treatment of work-related injuries or occupational diseases (hereinafter referred to as "illness(es)").

1. It is therefore the policy of the Office of Workers' Compensation that medical bills for services should be sent to the Carrier/Self-Insured Employer for payment. Fees for covered services in excess of the amounts allowable under the terms of this schedule are not recoverable from the employer, insurer, or employee.

2. It is also deemed to be in the best interest of all of the parties in the system that fees for services reasonably performed and billed in accordance with the reimbursement schedule should be promptly paid. Not paying or formally contesting such bills by filing LDOL/WC 1008 (Disputed Claim for Compensation), with the Office of Workers' Compensation within 60 days of the date of receipt of the bill may subject the Carrier/Self-Insured Employer to penalties and attorneys fees. Additionally, frivolous contesting of the bill may subject the Carrier/Self-Insured Employer to penalties and attorneys fees.

3. If claimant is receiving treatment for both compensable and non-compensable medical conditions, only those services provided in treatment of compensable conditions should be listed on invoices submitted to the Carrier/Self-Insured Employer unless the non-compensable condition (e.g. hypertension, diabetes) has a direct bearing on the treatment of the compensable condition. In addition, payments from private payers for non-compensable conditions should not be listed on invoices submitted to the Carrier/Self-Insured Employer. If a provider reasonably doesn't know the workers' compensation status, or the workers' compensation insurer has denied coverage, the provider won't be penalized for not complying with this rule. Upon notification or knowledge of workers' compensation eligibility, the provider shall comply with these regulations prospectively.

4. Statements of charges shall be made in accordance with standard coding methodology as established by these rules, ICD-9-CM, HCPCS, and CPT-4 coding manuals. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the purpose of inflating bills or reimbursement is strictly prohibited. Services must be coded and charged in the manner guaranteeing the lowest charge applicable. Knowingly and willfully misrepresenting services provided to workers' compensation claimants is strictly prohibited.

5. Providers should take reasonable steps to ensure that only those services provided are billed to the Carrier/Self Insured Employer. Violation of this provision may subject provider/practitioner to mandatory audit of all charges.

6. Bills for a particular charge item may not be included in subsequent billings without clear indication that they have been previously billed.

7. These rules shall be used in addition to all the reimbursement rules.

8. For purposes of these utilization review rules, persons performing such, shall be certified in accordance with the certification provisions as found in LA R.S. 40:2721, et.,seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and T of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L.R. 17:653 (Jul., 1991). Re 17:NNN, (MMM, 1991).

§ 2703. Introduction

A. Managed care activities are defined as a set of coordinated cost and utilization management activities by the Carrier/Self-Insured Employer to assure appropriate payment for health care services rendered to employees eligible for workers' compensation benefits in the State of Louisiana.

1. Pre-admission certification review is the cornerstone of utilization management. The pre-admission certification review notice (i.e. telephone call or written notification) is the claimant's entry into the benefits management system and triggers other utilization management functions. During pre-admission certification review, all utilization management activities can be coordinated. When cases are reviewed before hospitalization, this activity works to promote appropriate lengths of stay, discharge planning, and ambulatory care.

The pre-admission certification program reviews and certifies, before hospitalization, that a proposed hospital admission is both medically necessary and appropriate. It is not a process of substituting judgement for that of the physician, but rather making a determination of what level of care is to be reasonable and necessary under the provisions of the Louisiana Workers' Compensation Act.

2. The following managed care activities required by the Louisiana Workers' Compensation Act are described: pre-admission certification, admission certification, continued stay review (including length of stay assignment), discharge planning, reporting standards and dispute resolution, ambulatory surgery, and second surgical opinion.

B. Definitions

1. *Admission Review* - The review of the medical necessity and appropriateness of hospital admissions. The review takes place after the admission, but within a stated time frame.

2. *Ambulatory Review* - The review of the medical necessity and appropriateness of services rendered to claimants in out-of-hospital settings (e.g., skilled nursing facility, home health services, physician's office, and outpatient ancillary services).

3. *Appeals Process* - A physician, hospital, or a claimant may appeal to the Carrier/Self-Insured Employer to change its decision regarding payment for an inpatient admission, an extension of a length of stay, a specific treatment or for a claim for medical services. The appeals process is formally written and includes specific time frames, how the process works and who makes the final decision. The final step in the appeals process is a review by the Office of Workers' Compensation Administration.

4. *Utilization Management Program* - A comprehensive set of integrated utilization management components including: pre-admission certification review, admission review, second surgical opinion, continued stay review, and discharge planning.

5. *Continued Stay Review* - The review of an ongoing inpatient hospitalization to assure that it remains the most appropriate setting for the care being rendered.

6. *Discharge Planning* - The process of assessing a claimant's need

for medically appropriate treatment after hospitalization to effect an appropriate and timely discharge. The hospital and attending physician have major responsibility for this function with the Carrier/Self-Insured Employer promoting, monitoring, and assisting the hospital.

7. ***Pre-Admission Certification Review*** - The review and assessment of the medical necessity and appropriateness of hospital admissions before hospitalization occurs. The appropriateness of the site or level of care is assessed along with the timing and duration of the proposed hospitalization.

8. ***Second Surgical Opinion*** - Second surgical opinion programs enable claimants to receive a consultation from a second physician before undergoing specified surgical procedures. The consulting opinion does not have to confirm the original recommendation for surgery, however, the decision to have or not to have the surgery remains with the claimant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and T of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L.R. 17:653, (Jul., 1991). R 17:NNN, (MMM, 1991).

§ 2705. Pre-Admission Certification

A. Pre-admission certification is the review and assessment of the medical necessity and appropriateness of non-emergency hospital admissions before hospitalization has occurred. The appropriateness of the site and the level of care is assessed along with the timing of the proposed admission. Actual payment for services is also contingent upon the Carrier/Self-Insured Employers verification of:

1. Claimant's entitlement to benefits at the time hospitalization actually occurs, and

2. Statutory coverage for the care that is actually provided.

B. Application for pre-admission certification should be made prior to admission to the hospital unless the admission to the hospital is for a compensable illness or bodily injury that occurs without warning and requires immediate inpatient treatment to prevent death, or serious impairment of patient function. In the event an inpatient admission is for treatment of such a medical emergency, notification shall be made to the Carrier/Self-Insured Employer within 48 hours of admission.

C. The pre-admission certification process follows the sequence below:

The physician, hospital, or claimant must initiate the pre-admission certification process by calling the Carrier/Self-Insured Employer. The reviewer will request the following information:

1. Claimant name
2. Social Security number
3. Date of injury
4. Claimant's address
5. Sex
6. Claimant's date of birth
7. Name of hospital
8. Hospital address
9. Anticipated admission date
10. Admitting diagnosis (to include ICD-9 codes)*
11. Expected length of stay
12. Major procedures and related CPT codes*
13. Plan of treatment
14. Complications or other factors requiring the inpatient setting
15. Medical justification for inpatient admission
16. Is surgery anticipated? If yes, procedure.
17. Is general anesthesia required?
18. Admitting physician's name
19. Admitting physician's address
20. Admitting physician's phone number
21. Admitting physician's Tax ID or Social Security Number
22. Caller's name and number

* The provider will provide descriptive/narrative information and the reviewer, representing the Carrier/Self Insured Employer, will provide the ICD-9-CM and/or CPT-4 codes.

D. Pre-Admission Review Procedures

1. The Carrier/Self-Insured Employer must be able to administer a program where pre-admission certification review is initiated by the physician, hospital or claimant. Once the caller has made the first phone call to notify the Carrier/Self-Insured Employer of proposed hospitalization, the Carrier/Self-Insured Employer shall follow through with phone calls and written confirmations to the claimant, physician and hospital.

2. Pre-admission certification review is primarily conducted by telephone during normal business hours (8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday, excluding legal holidays) to assure quick responses. Written requests for pre-admission certification shall be processed by the Carrier/Self-Insured Employer on a case by case basis.

3. The Office of Workers' Compensation Administration will require annual reports on all workers' compensation medical review activity. Automated software support for the review process is recommended in order to assure timely responses, uniform administration, and complete data gathering.

4. All non-emergency hospital admissions shall be reviewed using nationally accepted criteria designed to assess the need for the acute level of care. The Managed Care Appropriateness Protocol (MCAP) and the Intensity/Severity/Discharge (ISD) criteria are the only two accepted criteria

for admissions.

The AEP manual is available from:

Utilization Management Associates, Inc.
888 Worcester Street, 3rd Floor
Wellesley, MA 02181
(617) 237-6822

The Adult ISD Criteria and Review System is available from Inter Qual:

293 Boston Post Road West
Suite 180
Marlborough, MA 01752
(508) 481-1181

44 Lafayette Road
Post Office Box 988
North Hampton, NH 03862-0988
(603) 964-7255

5. When the medical necessity of a proposed hospitalization is approved or certified, an expected length of stay is assigned. The length of stay is assigned using the most current edition of the Length of Stay by Diagnosis and Operation, Southern Region as published by HCIA. The LOS is available from:

HCIA, Inc
300 East Lombard Street
Baltimore, MD 21202 (1-800-568-3282)

6. The Carrier/Self-Insured Employer shall use registered nurses for the initial review of recommended hospitalization. Registered nurses will use written criteria provided in number 4 (above) of Pre-Admission Review Procedures of this manual to assess proposed hospitalizations. Physicians of same specialty shall review all questionable cases and make the Carrier/Self-Insured Employer decisions on all denials of certifications.

Within five (5) calendar days of receipt of the request, a response shall be generated in writing as to whether or not the admission is approved or denied. Verbal response shall be given within two (2) working days from the time of the request followed by the written response. Copies of the written response shall be sent to the attending physician, the hospital, and the claimant and shall notify the parties of the right to appeal and the appeal process. Sample letters are enclosed as Exhibit 3.

7. An appeals process shall be available for reconsideration of any denial decisions. If the admitting physician, hospital, or claimant desires to appeal a denial of an admission or continued stay request, the appeals process is initiated by contacting the Carrier/Self-Insured Employer by telephone or other immediate means following receipt of the denial. An appeal shall be requested with fifteen (15) days of receipt of the denial. After the appeal request is received, it shall be referred to the Carrier/Self-Insured Employer Medical Director or physician consultant in the same specialty. The Carrier/Self-Insured Employer Medical Director or physician consultant shall review the available information regarding the request and make a decision

concerning the appeal within 48 hours of receipt/communication of the appeal.

If the Carrier/Self-Insured Employer Medical Director decision is an *approval* of the appeal the admitting physician and hospital shall be immediately notified via telephone and follow up by letter shall be sent to the physician, claimant, and hospital.

If the Carrier/Self-Insured Employer Medical Director's decision is a *denial* the Carrier/Self-Insured Employer shall notify the admitting physician and hospital and shall immediately submit in writing the denial and case documentation by FAX to the Director of the Office of Workers' Compensation for review at (504) 342-6556. The material shall be clearly identified as a denial of hospital admission and shall be addressed "Attention: Medical Manager, Office of Workers' Compensation." The Director shall immediately review the case and shall notify the Carrier/Self-Insured Employer, admitting physician, and hospital by telephone of his agreement or disagreement with the denial decision. Follow-up notification shall be sent to the Claimant, Carrier/Self-Insured Employer, Hospital, and Admitting Physician by certified mail return receipt requested. Any party who disagrees with the Director's resolution may file a Disputed Claim For Compensation form (LDOL-WC-1008), available from the Office of Workers' Compensation Administration as otherwise provided by law.

8. Review nurses shall coordinate related managed care activities with the pre-admission certification request. For example, compliance with a second surgical opinion component should be checked during the physician's initial call.

9. The review process is also used to identify and refer cases for discharge planning.

10. The Carrier/Self-Insured Employer shall provide written notification of the review decision to the claimant, attending physician and the hospital.

11. The Carrier/Self-Insured Employer shall maintain appropriate internal documentation of each request for pre-admission certification to verify the process and the decision for claims processing and reporting purposes.

If a patient does not enter the hospital on the proposed date of admission (or within 15 days following that date) re-certification is required. In such cases the caller shall contact the Carrier/Self-Insured Employer to re-affirm the previously submitted pre-certification data and have the admission re-certified.

E. Pre-Admission Review Preparation

1. Preparation

a. Educational Program for Providers

The Carrier/Self-Insured Employer shall develop and distribute provider notices announcing the pre-admission certification program, describing the reasons for implementation and operation, including an explanation of the appeals process. This notice of the pre-admission certification program shall be included in local Carrier/Self-Insured Employer provider newsletters.

b. Pre-admission Review Forms

The Carrier/Self-Insured Employer may use the samples attached (Exhibit 1 and 2) or develop forms to capture pertinent patient and provider information during the pre-admission certification activity. These forms may be identical to those used by the Carrier/Self-Insured Employer for their other business. However, they should capture the statistical data elements required by the Office of Workers' Compensation Administration.

Exhibit 1 **Pre-Cert Activity Sheet**

Name of Claimant	SS #	Date of Injury
Address of Claimant/City/State/Zip Code		
Sex Male ___ Female ___	Claimant's Date of Birth	
Name of Hospital		
Address/City/State/Zip Code		
Proposed date of admission	Diagnosis and/or ICDA 9 CM	Expected length of stay
Major Procedure	Plan of Treatment	Complications
Medical Justification		
Primary Physician	Caller's name & number	
Attending Physician Name	Phone Number	
Address/City/State/Zip Code		
Is surgery Anticipated _____YES _____NO	If yes procedures:	Is Gen Anesthesia Req. _____ YES _____ NO

Date_____ PAS _____ days Certification #_____

APPEAL **OUT PT** **HHC/SNF** **RECERT** **CHANGES** **N&M**

RECERTS

1. No. of Recert days _____
No of Recert days to show _____
File D/C - Active _____
Date: _____

2. No. of Recert days _____
No of Recert days to show _____
File D/C - Active _____
Date: _____

3. No. of Recert days _____
No of Recert days to show _____
File D/C - Active _____
Date: _____

4. No. of Recert days _____
No of Recert days to show _____
File D/C - Active _____
Date: _____

5. No. of Recert days _____
No of Recert days to show _____
File D/C - Active _____
Date: _____

CHANGES

Date of Service _____

Change
_____

Exhibit 2 **Pre-Certification Case Notes**

Claimant's Name	Claimant No.	Precert No.

DATE	CLAIMANT STATUS	RECERT DAYS

c. Standardized Form Letters

The Carrier/Self-Insured Employer shall develop letters announcing results of the pre-admission certification process to: a) claimant; b) the admitting physician; or c) the hospital, with appeals process information where necessary.

Exhibit 3 **Pre-Admission Approval Letter**

Re: Patient:
Pre-Admission Certification No.:
Claimant No.:
Date of Service:
Date of Surgery:
Hospital:

The admission to the hospital referenced above has been initially approved for (number of days) days.

IT IS IMPORTANT FOR YOU TO KNOW THAT.....

this approval of the inpatient hospital setting is based on information provided by the above listed hospital and/or physician.

THE DETERMINATION OF ACTUAL BENEFITS.....

can only be made upon receipt of the completed claim. Payment for the services received is subject to statutory limitations. Eligibility is dependent upon:

1. The medical necessity for the services provided.
2. The work-relatedness of the illness or injury.

IF THE CLAIMANT REQUIRES CONTINUED HOSPITALIZATION BEYOND THE NUMBER OF DAYS APPROVED.....

the admitting physician or authorized hospital representative shall contact the Carrier/Self-Insured Employer at (phone number) on or before the above days expire.

BENEFITS FOR SERVICES RENDERED DURING ADDITIONAL HOSPITAL DAYS NOT CERTIFIED MAY BE DENIED.

Exhibit 3-B **Pre-Admission Denial Letter**

RE: Patient:
Pre-certification No.:
Contract No.:
Date of Service:
Date of Surgery:
Hosp:

Dear (Claimant/Physician/Provider)

The Medical Director for (Carrier/Self-Insured Employer) has carefully reviewed the pre-certification request for admission to the hospital referenced above.

Based upon information obtained, it has been determined that the medical necessity of the admission has not been documented.

As a result of the findings, this letter is to notify you that (Carrier/Self-Insured Employer) will not consider payment for the requested admission.

If you disagree with this decision, you may appeal in accordance with the guidelines attached.

Sincerely,

2. Implementation

a. Telephone Inquiry Service

Telephone numbers shall be published in educational materials and standardized form letters to the physicians, hospitals, and claimants. This telephone service allows for prompt response to requests for review and to general inquiries about the review process.

b. Appropriate Staff And Documentation For Program Management Of Certified, Denied And Appealed Admissions

Registered nurses and physicians are the required staff for processing of pre-admission certification requests and inquires. Procedures shall be available for timely review of appealed or denied admissions by a physician (a psychiatrist for mental illness or substance abuse admissions). Program procedures shall be routine and documented.

3. Evaluation

a. Data Collection

Pre-admission certification documentation shall be linked to the payment system to properly process inpatient claims. The pre-admission certification documentation shall be retrievable on a claim-by-claim basis for compilation and classification of activity performance.

b. Carrier/Self-Insured Employer Data Reporting

Carrier/Self-Insured Employer shall be required to collect the following data according to the Office of Workers' Compensation Administration requirements.

Information	# Positions/Type
1. ICD - 9 Diagnosis Code	5 Numeric
2. Provider Name	30 Alpha
3. Provider Street Address	30 Alpha Numeric
4. Parish Code for Provider of Service (Use Standard FIPS code, see Exhibit 5)	3 Numeric
5. Place of Treatment	1 Alpha Numeric
6. Type of Facility*	6 Numeric
7. Type of Service: Medical vs. Surgical	1 Alpha Numeric
8. Claimant Name	30 Alpha
9. Claimant Social Security Number	9 Numeric
10. Length of Stay	4 Numeric

* See "Type Facility Codes" in Exhibit 6.

Exhibit 5

F.I.P.S. AREA CODES

001	ACADIA	045	IBERIA	089	ST. CHARLES
003	ALLEN	047	IBERVILLE	091	ST. HELENA
005	ASCENSION	049	JACKSON	093	ST. JAMES
007	ASSUMPTION	051	JEFFERSON	095	ST. JOHN THE BAPTIST
009	AVOYELLES	053	JEFFERSON DAVIS	097	ST. LANDRY
011	BEAUREGARD	055	LAFAYETTE	099	ST. MARTIN
013	BIENVILLE	057	LAFOURCHE	101	ST. MARY
015	BOSSIER	059	LA SALLE	103	ST. TAMMANY
017	CADDO	061	LINCOLN	105	TANGIPAHOA
019	CALCASIEU	063	LIVINGSTON	107	TENSAS
021	CALDWELL	065	MADISON	109	TERREBONNE
023	CAMERON	067	MOREHOUSE	111	UNION
025	CATAHOULA	069	NATCHITOCHES	113	VERMILLION
027	CLAIBORNE	071	ORLEANS	115	VERNON
029	CONCORDIA	073	OUACHITA	117	WASHINGTON
031	DESOTO	075	PLAQUEMINES	119	WEBSTER
033	E. BATON ROUGE	077	POINTE COUPEE	121	W. BATON ROUGE
035	EAST CARROLL	079	RAPIDES	123	WEST CARROLL
037	EAST FELICIANA	081	RED RIVER	125	WEST FELICIANA
039	EVANGELINE	083	RICHLAND	127	WINN
041	FRANKLIN	085	SABINE		
043	GRANT	087	ST. BERNARD	998	OUT-OF-STATE

Exhibit 6a

TYPE OF FACILITY CODE

GENERAL TYPE PROVIDER (Position 1 & 2)

00 Not Licensed
01 Hospital*
02 Skilled Nursing Facility*
03 Custodial Nursing/Rehab Facility
04 Physician (M.D.)
05 Home Health Agency*
06 Dentist (D.M.D. - D.D.S.)
07 Pharmacy (not hospital)
10 Ambulance (non-hospital)
11 Podiatrist (D.P.M.)
12 Psychologist (Ph.D)
13 Chiropractor
14 Osteopath (D.O.)
15 Registered Nurse (R.N.)
16 Surgical Center (free standing)
17 Radiation Center (free standing)
18 Renal Dialysis Center (free standing)
19 Certified Registered Nurse Anesthetist (CRNA)
20 Physical Therapist
21 Optometrist
22 Registered Sitter
23 Optical Dispensary
24 Medical/Surgical Supply Organization
25 Other Para-Medical
26 Hearing Aid Dealers
27 Audiologist
28 Speech Pathologist
29 Social Worker
30 Licensed Practical Nurse
31 Public Conveyance
32 Rehabilitation Center
33 Pre-admit Testing Facility
34 Alcohol/Drug Rehabilitation Center (CDU) Detox Services Only
35 Psychiatric Hospitals - Inpatient and Outpatient
36 Alcohol/Drug Rehab Center (CDU)
37 Special Care Unit - Behavior Modification
38 Outpatient Surgical Unit (Hospital Based)
39 Hospice
40 Licensed Massage Therapist (MA)
41 Doctor of Education (Ed D)
42 Lithotripter Facility
43 Master of Science (M.S.)
44 Certified Substance Abuse Counselor (CSAC)
45 Counseling & Biofeedback Therapy
46 Family Counseling, Pastoral Counseling
47 Oriental Medical Doctor (O.M.D.)
48 Certified Surgical Technician (C.S.T.)
49 Doctor of Divinity (D.D.)
50 Private Duty Nursing
51 Multiple Specialties
52 Radiology (Non-Hospital)
53 VA/Military Hospital/Acute Care
54 VA/Military Hospital/Psychiatric
55 VA/Military Hospital/CDU
56 VA/Military Hospital/SNF
57 VA/Military Hospital/HHA
58 VA/Military Hospital/Ambulatory Surgery
59 Registered Dietitian (R.D.)
60 Cardiac Catherization Facility
61 Residential Treatment Center
62 Eating Disorder Treatment Facilities
63 Physician's Assistant
64 Third Party Liability
65 Emergency Room Physicians
66 Medical Staff Services
67 Mental Health Clinic
68 Sperm Banks
69 Home Infusion Therapy

* If position 1 & 2 is 01, 02,or 05, use the additional codes on the next page, otherwise the remaining four positions of the TYPE FACILITY CODE may be filled with zeroes (0's).

Exhibit 6b

TYPE OF FACILITY CODE

SPECIFIC TYPE PROVIDER
(Position 3 and 4)

If GENERAL TYPE
(Position 1 & 2) is 01:

01 General Short Term
02 General Long Term
03 TB
04 Psychiatric
05 Chronic Disease
06 Specialty Short Term
07 Specialty Long Term
08 Christian Science
09 All Others

If GENERAL TYPE
(Position 1 & 2) is 02:

01 Skilled Nursing Facility
02 E. C. Unit of Hospital
03 E. C. Unit of Rehabilitation Center
04 E. C. Unit of Domiciliary Institution
05 Distinct part of S.N.F.
06 Christian Science
07 Combined with Intermediate Care
08 Intermediate Care Facility only
09 Other

If GENERAL TYPE
(Position 1 & 2) is 05:

01 Visiting Nurse Association
02 Combined Govt. and Vol. Agency
03 Official Health Agency
04 Rehab. Facility Based Program
05 Hospital Based Program
06 S.N.F. Based Program
07 Proprietary
08 Other

OWNERSHIP/
MANAGEMENT
(Position 5 and 6)

If GENERAL TYPE
(Position 1 & 2) is 01 or 02 or 05:

01 Church
02 Other Than Church
03 Proprietary
04 State
05 Parish (County)
06 City
07 City-Parish (County)
08 Hospital District
09 P.H.S. (Fed. Gov't)
10 Other than P.H.S. (Fed. Gov't)
11 All Other
12 Non-Profit

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). 17:NNN, (MMM, 1991).

§ 2707. Admission and Continued Stay Review

A. In those instances when an emergency hospital admission is involved, an admission review shall be conducted. Admission review determines the medical appropriateness of the admission and utilizes the same techniques employed in pre-admission certification review such as reviewing all pertinent medical information against a set of accepted medical criteria to evaluate the need for hospital level of care. Non-emergency admissions that have not been pre-certified by pre-admission certification review are also monitored through admission review. If the admission is considered appropriate, a reasonable length of stay is assigned using a set of standard criteria. The admission review and continued stay review follow the sequence below.

B. Continued stay review is the review of the *appropriateness and necessity of continued hospitalization* while the patient is still in the hospital. The review is conducted using acceptable medical criteria to evaluate the appropriateness of continued hospital level of care. The same criteria used in pre-admission certification review are used during continued stay review. The day before the expected discharge date, the case shall be reviewed to determine if hospital level of care is still needed. If additional inpatient care is necessary, review personnel shall authorize an extension of the length of stay.

C. Continued stay review is an integral part of managed care. During continued stay review, review personnel can identify cases that will benefit from individual case management. Continued stay review permits the review personnel to become aware of changes in a patient's condition or slow recovery which may necessitate a longer hospital stay.

D. Admission and Continued Stay Review Procedures

1. The Carrier/Self-Insured Employer shall automatically review the necessity for continued hospitalization the day before the initial length of stay assigned expires without claimant initiation responsibility. The responsibility to request an extension may be delegated to the hospital if requested by the hospital and agreed to in writing by the Carrier/Self-Insured Employer. If the party who has the responsibility for initiating the continued stay review fails to do so, they shall be responsible for the cost of any subsequent care provided.

2. Continued stay review shall include telephone discussions with the hospital or physician if the information required is not available from the

hospital. All pertinent information necessary to determine if continued hospitalization is medically necessary and appropriate will be gathered (i.e. current medications and methods of administration used, frequency, lab values, and results of diagnostic tests). If re-certification is appropriate, additional days are assigned based upon LOS manual using the medical judgement of the reviewer. This process shall continue until the patient is discharged or until documentation no longer supports the medical necessity for inpatient services. If re-certification is not medically necessary or appropriate based upon documentation reviewed, the Medical Director of the Carrier/Self Insured Employer shall issue a denial to the physician, claimant, and hospital by the close of business (4:30 p.m. Central Time) on the day of the review.

3. All non-elective acute care hospital admissions including emergencies, psychiatric admissions, and all extended hospitalizations are reviewed using nationally accepted criteria designed to assess the need for hospital level of care. The Managed Care Appropriateness Protocol (MCAP) and the Intensity/Severity/Discharge (ISD) criteria are the only two accepted criteria for admissions.

4. Automated software support for the review process is recommended in order to assure timely responses, uniform administration and complete data gathering. Computer prompts may be especially important in following up on length of stay assignments and assuring timely continued stay review.

5. Registered nurses use written criteria to assess the need for continued stay in the hospital. Physicians of same specialty review all questionable cases and shall make the *final* Carrier/Self-Insured Employer decisions on all denials of certification.

6. An appeals process shall be available for reconsideration of any denial decisions. If the admitting/treating physician, hospital, or claimant desires to appeal a denial of an admission or continued stay request, the appeals process is initiated by contacting the Carrier/Self-Insured Employer by telephone or other immediate means following receipt of the denial. The appeal shall be requested within fifteen (15) days of the receipt of denial. After the appeal request is received, it shall be referred to the Carrier/Self-Insured Employer Medical Director or physician consultant. The Carrier/Self-Insured Employer Medical Director or physician consultant shall review the available information regarding the request and make a decision concerning the appeal within 48 hours of receipt/communication of the appeal.

If the Carrier/Self-Insured Employer Medical Director's decision is an *approval* of the appeal the admitting/treating physician and hospital shall be immediately notified via telephone and follow up by letter will be sent to the physician, claimant, and hospital.

If the Carrier/Self-Insured Employer Medical Director's decision is a *denial* the Carrier/Self-Insured Employer shall notify the admitting/treating physician and hospital and shall immediately submit in writing the denial and case documentation by FAX to the Director of the Office of Workers' Compensation for review at (504) 342-6556. The material shall be

clearly identified as a denial of an admission or continued hospital stay request and shall be addressed "Attention: Medical Manager, Office of Workers' Compensation." The Director shall immediately review the case and shall notify the Carrier/Self-Insured Employer, the admitting/treating physician, and hospital by telephone of his agreement or disagreement with the denial decision. Follow-up notification shall be sent to the Claimant, Carrier/Self-Insured Employer, hospital, and admitting/treating physician by certified mail return receipt requested. Any party who disagrees with the Director's resolution may file a Disputed Claim For Compensation form (LDOL-WC-1008), available from the Office of Workers' Compensation Administration as otherwise provided by law.

7. The review process is also used to identify and refer cases for discharge planning.

8. The program includes written notification of the continued stay review decision to the claimant, physician and the hospital.

9. The Carrier/Self-Insured Employer maintains appropriate internal documentation of each request for continued stay review to verify the process and the decision for claims processing and reporting purposes.

E. Admission And Continued Stay Review Preparation

1. Preparation

a. Educational Program for Providers

The Carrier/Self-Insured Employer shall maintain and make available to the provider information regarding the admission and continued stay review certification program, describing the reasons for implementation and operation, including an explanation of the appeals process. This notice of the admission and continued stay review program shall be included in local Carrier/Self-Insured Employer provider newsletters.

b. Admission and Continued Stay Review Forms

The Carrier/Self-Insured Employer may use samples attached (Exhibit 1 and 2) or develop forms to capture pertinent patient and provider information during the admission and continued stay review activity. These forms may be identical to those used by the Carrier/Self-Insured Employer for their other business, however, they should capture the statistical data elements required by the Office of Workers' Compensation Administration.

c. Standardized Form Letters

The Carrier/Self-Insured Employer shall develop letters announcing the results of the admission and continued stay review process to: a) claimant; b) the admitting/treating physician; and c) the hospital, with appeals process information where necessary.

Exhibit 3-A **Continued Stay Approval Letter**

Re: Patient:
Pre-Admission Certification No.:
Claimant No.:
Date of Service:
Date of Surgery:
Hospital:

Additional days to the hospital referenced above have been approved based upon a determination of medical necessity for continued inpatient care. A total of (indicate number of days) days is available for this hospital stay.

IT IS IMPORTANT FOR YOU TO KNOW THAT.....

this approval of the inpatient hospital setting is based on information provided by the above listed hospital and/or physician.

THE DETERMINATION OF ACTUAL BENEFITS.....

can only be made upon receipt of completed claim. Payment for the services received is subject to statutory limitations. Eligibility is dependent upon:

1. The medical necessity for the services provided.
2. The work-relatedness of the illness or injury.

IF THE CLAIMANT REQUIRES CONTINUED HOSPITALIZATION BEYOND THE NUMBER OF DAYS APPROVED.....

the admitting physician or authorized hospital representative should contact the Carrier/Self-Insured Employer at (phone number) on or before the above days expire.

BENEFITS FOR SERVICES RENDERED DURING ADDITIONAL HOSPITAL DAYS NOT CERTIFIED MAY BE DENIED.

Exhibit 3-C **Continued Stay Denial Letter**

RE: Patient:
Pre-certification No.:
Contract No.:
Date of Service:
Hosp.:

Dear (Claimant/Physician/Provider)

The Medical Director has reviewed carefully your current medical status and, based upon the information obtained, has determined that the medical necessity of further hospitalization has not been documented.

Charges for inpatient services after (date), at the hospital referenced above will not be considered for payment.

If you disagree with this decision, you may appeal in accordance with the guidelines attached.

Sincerely,

2. Implementation

a. Telephone Inquiry Service

Telephone numbers shall be published in educational materials and standardized form letters to the physicians, hospitals, and claimants. This telephone service allows for prompt response to requests for review and to general inquires about the review process.

b. Appropriate Staff and Documentation for Program Management of Certified, Denied, and Appealed Admissions

Registered nurses and physicians are the required staff for processing of admission and continued stay review requests and inquiries. Procedures shall be available for timely review of appealed or denied admissions by a physician of the same specialty (a psychiatrist for mental illness or substance abuse admissions). Program procedures shall be routine and documented.

3. Evaluation

a. Data Collection

Admission and continued stay review documentation shall be linked to the claims system to properly process inpatient claims. The admission and continued stay review documentation shall be retrievable on a claim-by-claim basis for compilation and classification of activity performance.

b. Carrier/Self-Insured Employer Data Reporting

Carrier/Self-Insured Employer shall be required to collect data according to the Office of Workers' Compensation Administration requirements:

Information	# Positions/Type
1. ICD - 9 Diagnosis Code	5 Numeric
2. Provider Name	30 Alpha
3. Provider Street Address	30 Alpha Numeric
4. Parish Code for Provider of Service (Use Standard FIPS code, see Exhibit 5)	3 Numeric
5. Place of Treatment	1 Alpha Numeric
6. Type of Facility*	6 Numeric
7. Type of Service: Medical vs. Surgical	1 Alpha Numeric
8. Claimant Name	30 Alpha
9. Claimant Social Security Number	9 Numeric
10. Length of Stay	4 Numeric

* See Exhibit 6.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and

of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). 17:NNN, (MMM, 1991).

§ 2709. Discharge Planning

Discharge planning is the process of assessing a patient's need for treatment after hospitalization and effecting an appropriate and timely discharge. The hospital has major responsibility for this function with the Carrier/Self-Insured Employer promoting, monitoring, and assisting the hospital.

A. Discharge Planning Procedures

1. Discharge planning is primarily the responsibility of the hospital.

2. The Carrier/Self-Insured Employer supports discharge planning by identifying and referring patients who may need discharge planning, by assisting the hospital with information on statutory coverage and alternative providers, and by monitoring hospitals to assure that appropriate discharge planning services are provided.

3. Discharge planning cases are identified primarily by the hospital. These services may not be duplicated by the Carrier/Self-Insured Employer if they are provided by the hospital. However, in addition, the Carrier/Self-Insured Employer identifies cases through pre-admission certification, admission review, continued stay review, and other managed care activities.

4. The Carrier/Self-Insured Employer requires appropriate hospital documentation on cases processed through discharge planning.

B. Discharge Planning Preparation

1. Preparation

a. Discharge Planning Information

The Carrier/Self-Insured Employer shall capture pertinent patient and provider data during the discharge planning activity. This information may be identical to that used by the Carrier/Self-Insured Employer for their other business, however it should include the statistical data elements required by the Office of Workers' Compensation Administration.

b. Screening for Cases

The Carrier/Self-Insured Employer should identify the cases that are most likely to require discharge planning. This process can be initiated during the pre-admission certification activity to identify cases and to notify the hospital to begin discharge planning as soon as possible. The sooner the hospital discharge planner knows the patient's needs, the more likely it is that unnecessary days will be avoided.

2. Implementation

a. Telephone Inquiry Service

Telephone numbers shall be published in educational materials and standard form letters to hospitals and claimants. This telephone service shall provide for prompt response to general inquiries about the discharge planning process.

b. Monitoring the Hospital

The Carrier/Self-Insured Employer shall monitor the hospital's discharge planning activity on a case-by-case basis and an aggregate basis at regular intervals. Monitoring ensures that Louisiana workers' compensation claimants receive quality care. As part of the monitoring effort, the Carrier/Self-Insured Employer may require documentation from the medical records or abstract material on patients. Documentation should include information on the cases the hospital has seen, the discharge planning activity, the results of the activity and the problems encountered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). 17:NNN, (MMM, 1991).

§ 2711. Second Surgical Opinion

A. When surgery has been recommended by the treating physician, the Carrier/Self-Insured Employer is entitled to obtain a second professional opinion from a physician chosen by the Carrier/Self-Insured Employer in accordance with LA RS23:1121. Regardless of the second surgical opinion outcome, the claimant remains free to elect not to undergo surgery after the consultation. This program is designed to reduce unnecessary surgeries and to provide the claimant with possible alternate courses of treatment so that he or she can make an informed decision.

B. Second Surgical Opinion Procedures.

1. The Carrier/Self-Insured Employer is responsible for informing the claimant when a second surgical opinion is required and for referring the claimant to a second surgical opinion physician of like specialty.

2. The Carrier/Self Insured Employer shall notify all parties of the surgical request and of their action on the request within 15 calendar days of the date of receipt of the request. Failure to respond timely will imply that a second surgical opinion is not needed and that the surgical treatment is indicated, thus pre-certification must begin per Section 2705 of these rules.

3. The Carrier/Self-Insured Employer should have in place a process to waive second surgical opinions on the basis of defined criteria.

4. The Carrier/Self-Insured Employer shall develop manual procedures or develop an automated system for administering program requirements, selecting consultants, documenting claimant compliance with the program and efficiently handling claimant and physician contacts.

5. The second surgical consultation and tests necessary for the second surgical opinion consultation to render an opinion on the proposed surgery are to be paid by the Carrier/Self-Insured Employer.

6. The following is a list of surgical procedures that usually require a second opinion:

Spinal Surgery	Foot Surgery
Gastrectomy	Hemorrhoidectomy
Coronary Artery Bypass	Varicose Vein Surgery
Knee Surgery	Traumatic Cataract Surgery
Nasal Surgery	Joint Replacement

7. Second surgical opinion is not a substitution for other utilization review procedures and shall be performed in conjunction with the other procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and Training, Office of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). Repromulgated by L.R. 17:NNN, (MMM, 1991).

§ 2713. Ambulatory Surgery

A. Ambulatory surgery refers to a program which recommends that specified surgical procedures be performed on an outpatient basis. The program is designed to reduce unnecessary hospitalizations and to shift care to less costly settings if medically appropriate. The surgeon is responsible for following the specified guidelines for procedures which should be performed in an outpatient setting.

B. Ambulatory Surgery Procedures

1. The following is a list of surgical procedures and tests that are classified as primarily outpatient procedures not requiring hospitalization under normal circumstances:

Arthroscopy
Brush Biopsy of Stomach
Blood Transfusions
Carpal Tunnel Release
Closed Reduction Nasal Fracture
Cystoscopy

Closed Reduction of Dislocation or Fracture
Dx Radiological procedures in absence of acute admittable illness
Dx Ultrasound
Esophagoscopy
Exploration Tendon Sheath - Hand
Excision Lesion Tendon Sheath - Hand
Excision Lesion Tendon Sheath
Fiberoptic Bronchoscopy
Flex Fiberoptic Colonoscopy
Gastroscopy
Lid Reconstruction
Laryngoscopy/Tracheoscopy
Large Bowel Endoscopy
Laparoscopy
Other Larynx Diagnostic Procedures
Other Fusion of Toe
Other Skin & Subcutaneous Incision/Drainage
Other Local Destruction of Skin
Peripheral Nerve Biopsy
Plastic Repair External Ear
Partial Ostectomy
Sinus Puncture for Lavage
Surgical Tooth Extraction
Small Bowel Endoscopy - via existing surgical ostomy
Skin Incision & Foreign Body Removal
Skin & Subcutaneous Biopsy
Skin Suture
Turbinectomy by Diathermy/Cryosurgery
Turbinate Fracture
Tooth Extraction
Total Ostectomy - Digit
Tenotomy of Hand

2. The Carrier/Self-Insured Employer shall not waive ambulatory surgeries except on the basis of defined criteria, which must include at least the following:

a. Presence of other documented medical problems that make prolonged pre-operative or post-operative observation medically necessary;

b. Inability to provide proper post-operative care at home; and

c. Likelihood that another major surgical procedure might follow the initial procedure.

3. The Carrier/Self-Insured Employer should have an automated system for administering program requirements and documenting provider compliance with the program.

C. Ambulatory Surgery Preparation

1. Preparation

It is important to stress to the provider that the intent of the program is not to reduce the quality of care and to explain that Carrier/Self-Insured Employer consultant physicians are available to discuss cases for which the attending physician feels the surgery must be performed on an inpatient basis.

Drawing on the strength of existing physician relations, the Carrier/Self-Insured Employer needs to stress continued cooperation between the Carrier/Self-Insured Employer physician consultant and the attending physician. In addition, the Carrier/Self-Insured Employer should develop on-going physician communications, such as newsletters and attendance at community physician gatherings.

2. Implementation

a. Telephone Inquiry Service

Telephone numbers should be published in educational materials and standard form letters to physicians and claimants. This telephone service should provide for prompt response to inquiries regarding ambulatory surgery.

b. Appropriate Staff and Documentation

Registered nurses and physicians are the required staff for processing of ambulatory surgery requests and inquiries. Procedures must be available for timely review of cases which providers believe cannot be safely performed in an outpatient setting. Program procedures should be routine and documented.

3. Evaluation

a. Data Collection

Ambulatory surgery information should be linked to the claims system to properly process surgical claims. Ambulatory surgery elements should be retrievable on a claim-by-claim basis for compilation and classification of activity performance.

b. Plan Data Reporting

Carriers will be required to collect data for report preparation as outlined in the billing and maintenance section of the Office of Workers' Compensation Reimbursement Manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and

of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). 17:NNN, (MMM, 1991).

§2715. Reporting Standards and Dispute Resolution

A. Purpose

It is the purpose of this section to facilitate the management of medical care delivery, and to assure an orderly and timely process in the resolution of care-related disputes.

B. Statutory Limits

1. Non-Emergency Care

In addition to all other Utilization Review rules and procedures, the law (LA R.S. 23:1142) establishes a monetary limit for non-emergency medical care. The statute further provides significant penalties for a Carrier's/Self-Insured Employer's arbitrary and capricious refusal to approve necessary care beyond that limit.

a) Initial Request

Recognizing the importance of establishing a process for the making of such treatment decisions, the Office of Workers' Compensation Administration hereby promulgates the following criteria as the minimum submission by a provider or practitioner seeking to provide care beyond the statutory non-emergency medical care monetary limit:

- history and physical to include clinical summary
- diagnosis with ICD-9 codes*
- type of service
- plan of care to include expected length and frequency of treatment
- prognosis to include expected outcome of treatment
- any diagnostic test results and interpretation

* The provider will provide the narrative/description and the Carrier/Self Insured Employer will provide the ICD-9 code.

This information will help the reviewer determine the intensity of service needed to treat the patient.

In the absence of the submission of such information, any denial of further non-emergency care by the Carrier/Self-Insured Employer is *prima facie* not arbitrary and capricious.

b) Initial Review

(1) The Carrier/Self-Insured Employer shall use a registered nurse for the initial review of non-emergency treatment.

(2) The Carrier/Self-Insured employer shall notify all parties including claimant, provider, practitioner of the request and of their approval or denial of the requested treatment within 7 calendar days of date of receipt of the request. Failure to respond timely may result in assessment of penalties by the workers' compensation judge.

(3) If the Carrier/Self-Insured Employer's decision is an approval, the Carrier/Self-Insured Employer shall notify the requesting parties immediately via telephone and follow up by letter to the interested parties.

(4) Denials of recommended treatment shall be reviewed by a physician/practitioner of like specialty in accordance with LA RS 23:1121. If the results of this is an approval, follow procedure (3) above. If denied follow next procedures.

c) Review by Office of Workers' Compensation

(1) If the Carrier/Self-Insured Employer's physician/practitioner 's decision is a denial, the Carrier/Self-Insured Employer shall notify the requesting parties and shall immediately submit in writing the denial and any documentation relied upon in denying the recommended treatment by FAX to the Director of the Office of Workers' Compensation at (504) 342-6556. The material shall be clearly identified as a denial of medical services and shall be addressed "Attention: Medical Services Manager, Office of Workers' Compensation."

(2) The medical services section shall immediately review the case and notify the Carrier/Self-Insured Employer, claimant, and recommending provider/practitioner of the action on the review.

(3) In the event that there are opposing medical opinions regarding the necessity of the proposed or already performed medical treatment, the Office of Workers' Compensation Administration will appoint an independent medical examiner in the appropriate specialty to examine the claimant or review of medical records at issue in accordance to LA RS 23:1123 and 1291. The expense of this examination shall be borne by the Carrier/Self-Insured Employer.

(4) Upon completion of the review, by the Office of Workers' Compensation Administration, the Director shall issue a recommendation of the findings of the review to all parties via certified return receipt mail.

d) Filing of Disputed Claim LDOL-WC-1008

Any party who disagrees with the decision of the Office of Workers' Compensation Administration may file a disputed claim for compensation on the LDOL-WC-1008 form. These disputes shall be referred to the Hearing Section of the Office of Workers' Compensation and shall be handled as any other disputed claim.

e) Failure to Comply with Time Frames for Decisions

If the Carrier/Self-Insured Employer fails to follow through in obtaining information necessary to conduct their initial review or to conduct it's initial review in compliance with the time frames set out in this section, it shall be presumed that the recommended care has been denied and any interested party may immediately file a disputed claim form LDOL-WC-1008 as set out in subsection (d) above. In addition, failure to respond timely may result in assessment of penalties by the workers' compensation judge.

2. Emergency Care

In addition to all other rules and procedures, the provider or practitioner who provides care under the "medical emergency" exception shall demonstrate that it was a "medical emergency" in the following manner:

a. By demonstrating that the illness or condition presents one or more of the following findings:

1) Severity of Illness Criteria

a) Sudden onset of unconsciousness or disorientation (coma or unresponsiveness)

b) Pulse Rate:
(**i**) Less than 50 per minute
(**ii**) Greater than 140 per minute

c) Blood Pressure:
(**i**) Systolic less than 90 or greater than 200 mm Hg.
(**ii**) Diastolic less than 60 or greater than 120 mm Hg.

d) Acute loss of sight or hearing

e) Acute loss of ability to move body part

f) Persistent fever equal to or greater than 100 (p.o.) or greater than 101(r) for more than 5 days

g) Active bleeding

h) Severe electrolyte/blood gas abnormality (any of the following)
(**i**) Na < 124 mEq/L, or Na > 156 mEq/L
(**ii**) K < 2.5 mEq/L, or K > 6.0 mEq/L
(**iii**) CO_2 combining power (unless chronically abnormal) < 20 mEq/L, or CO_2 combining power (unless chronically abnormal) > 36 mEq/L
(**iv**) Blood ph < 7.30, or Blood ph > 7.45

i) Acute or progressive sensory, motor, circulatory or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, etc.) Note: Must also meet Intensity of Service criterion simultaneously in order to certify. Do not use for back pain.

j) EKG evidence of acute ischemia; must be suspicion of a new MI.
k) Wound dehiscence or evisceration.

- ***AND*** -

2) Intensity of Service Criteria

a) Intravenous medications and/or fluid replacement (does not include tube feedings)

b) Surgery or procedure scheduled within 24 hours requiring
(**i**) General or regional anesthesia or
(**ii**) Use of equipment, facilities, procedure available only in a hospital

c) Vital sign monitoring every 2 hours or more often (may include telemetry or bedside cardiac monitor)

d) Chemotherapeutic agents that require continuous observation for life threatening toxic reaction

e) Treatment in an I.C.U.

f) Intramuscular antibiotics at least every 8 hours.

g) Intermittent or continuous respirator use at least every 8 hours.

PLEASE NOTE: IF AT LEAST ONE CRITERION IS SATISFIED FROM BOTH THE SEVERITY OF ILLNESS CRITERIA AND THE INTENSITY OF SERVICE CRITERIA, THE SERVICE IS CONSIDERED TO BE EMERGENCY.

- ***OR*** -

b. By demonstrating by other objective criteria that the treatment was necessary to prevent death, or serious permanent impairment to the patient.

3. Change of Physician

Requests for change of treating physician within one field or specialty shall be made in writing to the Carrier/Self-insured Employer, and shall contain a clear statement of the reason for the requested change. Having exhausted the monetary limit for non-emergency treatment is insufficient justification, without other reasons. The Carrier/Self-Insured Employer shall notify all parties of the request, and of their action on the request, within 5 calendar days of date of receipt of the request. Failure to respond timely may result in assessment of penalties by the workers' compensation judge.

Disputes over change of physician will be resolved in the same

manner and subject to the same procedures as established for dispute resolution of claims for workers' compensation benefits.

C. Opposing Medical Opinions

In the event that there are opposing medical opinions regarding claimant's condition or capacity to work, the Office of Workers' Compensation Administration will appoint an independent medical examiner of the appropriate licensure class to examine the claimant, or review the medical records at issue in accordance to LA RS 23:1123. The expense of this examination shall be borne by the Carrier/Self-Insured Employer.

The medical examiner shall submit a report of the examination or review of medical reports within thirty (30) days from the examination date or the date of receipt of medical records for review.

Failure to do so, may cause the payment for services provided to be withheld until such report is received.

In addition to these rules, the independent medical examination or review of records is subject to other rules of the Office of Workers' Compensation governing such examinations.

Disputes over independent medical examinations set by the Director shall be resolved in the same manner and subject to the same procedures as established for dispute resolution of claims for workers' compensation benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). 17:NNN, (MMM, 1991).

§ 2717. Medical Review Guidelines

A. Workers' Compensation is designed to provide indemnity and medical care benefits for workers who sustain injuries or illnesses arising out of and in the course and scope of employment. The following instructions give some general guidelines for medical review of workers' compensation claims.

B. Technical Considerations for Review of Claims

Prior to a detailed medical review, a cursory review of the claim should be accomplished and should include at least the following:

1. Job related illness/injury must be identified

2. Each service/item billed must be identifiable

3. Billing period must be identified

4. Appropriate forms must be used and filled out completely

If the cursory review indicates that sufficient information is present, processing of the claim can proceed. If the review indicates information is lacking, the Carrier/Self-Insured Employer shall take immediate and appropriate action to obtain the information required. The "timely payment" provision contained in the Statement of Policy in this manual shall not apply until the required information is obtained. However, absence of non-essential information is not justification for delay in claim processing.

C. Functions of Medical Review

The Carrier/Self-Insured Employer should use a program of prevention and detection to guarantee the most appropriate and economical use of health care resources for claimants.

1. Prevention Through Education

Informing physicians and other health care providers about workers' compensation programs, policies and statutory provisions that deal with claim submission is the key to ensuring the appropriate billing of covered services. As part of that educational focus, the following are some of the administrative policies encountered in the review process:

Quality of Care
Medical Necessity
Screening Tests
Confidentiality
General Documentation Requirements

2. Quality of Care

The AMA characterizes quality of care as that level of care which contributes to the maintenance or improvement of a patient's health and well-being. Quality care should:

- Emphasize health promotion, disease and disability prevention, and early detection and treatment;

- Be provided in a timely manner, without inappropriate delay, interruption, premature termination or prolongation of treatment;

- Seek the patient's cooperation and participation in the decisions and process of his or her treatment;

- Be based on accepted principles of medical science and the skillful and appropriate use of other health professionals and technology;

- Be provided with sensitivity to the stress and anxiety that illness can cause, and with concern for the patient's and family's overall welfare;

- Use technology and other resources efficiently to achieve the treatment goal;

- Be sufficiently documented in the patient's medical record to allow continuity of care and peer evaluation.

3. Medical Necessity

The workers' compensation law provides benefits only for services that are medically necessary for the diagnosis or treatment of a claimant's work related illness, injury, symptom or complaint. To be medically necessary, a service must be:

- Consistent with the diagnosis and treatment of a condition or complaint; and

- Consistent with the standards of good medical practice; and

- Not solely for the convenience of the patient, family, hospital or physician; and

- Furnished in the most appropriate and least intensive type of medical care setting required by the patient's condition.

Services not related to the diagnosis or treatment of a work related illness or injury are not payable under the workers' compensation laws and shall be the financial responsibility of the claimant, and in appropriate cases, his health insurance carrier.

4. Screening Tests

A screening test not related to the on-the-job illness or injury is not covered under the workers' compensation law.

A screening test may be defined as a diagnostic procedure or test which is performed for a claimant in the absence of, or regardless of, his/her presenting sign(s), complaint(s), or symptom(s).

Although screening tests may reflect good medical practice, such tests are not covered under the workers' compensation program if not specifically related to the on-the-job illness or injury. For example, a standard battery of laboratory tests ordered without regard to a specific symptom or diagnosis consistent with the reported on-the-job illness or injury, is considered non-payable screening.

Payment for such test(s) shall be an enforceable obligation against the claimant and, in appropriate cases, his health insurance carrier, but shall not be an enforceable obligation against the employer or insurer.

5. Confidentiality

When it is necessary to request additional information to clarify

the need for services or substantiate coverage for a claim being reviewed, the Carrier/Self-Insured Employer must take particular care to ensure that all of its employees adhere to strict policy guidelines regarding claimant privacy. The Carrier/Self-Insured Employer shall require only sufficient information to allow a reviewer to make an independent judgement regarding diagnosis and treatment. Intimate details in a claimant's records are neither necessary nor desired, and are specifically protected by law.

6. General Documentation Requirements

The determination of appropriate reimbursement requires adequate documentation of services. The following items establish the minimum documentation requirements prior to payment:

a. Documentation for all services must be legible and signed by the health care provider, i.e. date(s) of service, type of surgery where applicable, diagnosis (not a list of symptoms).

b. Submitted documentation must contain sufficient data to substantiate the diagnosis and need for treatment on each date of service.

c. To substantiate medical necessity:

- It is essential to report the most complete and precise diagnosis(es) on the claim form.

- Service(s) billed should be appropriate for the diagnosis.

- Documentation in the clinical record (i.e., physical findings and historical data) should confirm the diagnosis and support the medical necessity and appropriateness of the service billed.

- Documentation should be available for each service billed.

d. The maintenance of adequate and accurate clinical records is a requirement for all physicians and hospitals. Documentation should be complete, including positive as well as negative findings, and should be recorded in a timely manner.

7. Detection

The Carrier/Self-Insured Employer detects the misuse of benefits through routine claims review, computer analysis, claims audit and the investigation of complaints. The carrier shall conduct such reviews and analysis on an ongoing basis and shall investigate all complaints in a timely manner. Referrals of appropriate cases may be made to the Office of Workers' Compensation Medical Review staff.

8. Prepayment And Postpayment Claim Review

A practitioner's or provider's claims may be selected for review by the Office of Workers' Compensation if utilization review procedures detect

a pattern of over-utilization of services. If a review indicates a possible overuse or misuse of services, the practitioner or provider will be notified in writing that he or she will receive a request for additional information on a sampling of submitted claims.

9. Referrals

The Office of Workers' Compensation Medical Review staff will investigate complaints from claimants, carriers, employers, physicians, other practitioners, and health care facilities, inquiries from the press or government agencies, referrals from other internal areas of the Office of Workers' Compensation, and even "leads" from various media sources (e.g., newspapers) if in the judgement of the Medical Manager such investigation is warranted. In appropriate cases, the Office of Workers' Compensation will refer evidence of over-utilization to the various licensing authorities.

D. Professional Justification

1. Medical Necessity

All claims submitted to the Carrier/Self-Insured Employer must be reviewed for medical necessity and for compliance with accepted standards of medical practice in order for payment to be made.

Medical necessity implies the use of technologies[1], services, or supplies provided by a hospital, physician, or other provider that is determined to be:

- Medically appropriate for the symptoms and diagnosis or treatment of the work related illness or injury; and

- Provided for the diagnosis or the direct care and treatment of the patient's illness or injury; and

- In accordance with standards of good medical practice; and

- Not primarily for the convenience of the patient, patient's family, practitioner or provider; and

- The most appropriate level of service that can be provided to the patient.

2. Additional Medical Record Information

It is the responsibility of the claimant and provider to furnish all medical documentation needed by the Carrier/Self-Insured Employer to determine if the injury or illness is job related and if the services are medically necessary for the condition of the claimant (e.g., physician office

[1] The term technology refers to any medical or surgical treatment, medical or surgical device, diagnostic procedure, drug, biological, or therapeutic or diagnostic agent.

record, hospital medical record, Dr.'s orders, treatment plan, vital signs, lab data, test results, nurses' notes, progress notes).

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated as Emergency Rule by Louisiana Department of Employment and of Workers' Compensation, L.R. 16:387, (Oct., 1990). Repromulgated by L. R. 17:653, (Jul., 1991). 17:NNN, (MMM, 1991).

§ 2719. Instructions for On-Site Audit of Hospital Charges

The carrier is authorized to conduct an on-site audit of hospital services related to a compensable injury or illness. This is accomplished by a line-by-line examination of billed charges, comparing the doctor's orders with supporting medical documentation in the patient's chart and the corresponding departmental records.

A. Applicability and Scope

The following audit guidelines shall be followed by hospitals and Carrier/Self-Insured Employer. Disputes between the Carrier/Self-Insured Employer and hospitals will be referred to the Louisiana Office of Workers' Compensation for final resolution. The hospital and/ or Carrier/Self-Insured Employer involved in the billing audit shall be responsible for the conduct and results of the billing audit whether conducted by an employee or by contract with another firm. This means that the hospital and Carrier/Self-Insured Employer shall:

1. Exercise proper supervision of the process to ensure that the audit is conducted according to the spirit of the regulations set forth here;

2. Be aware of the actions being undertaken by the auditor in connection with the billing audit and its related activities; and

3. Take prompt remedial action if inappropriate behavior by the auditor is discovered.

B. Definitions

For purposes of this section:

1. Ambulatory Surgical Center - ambulatory surgical center as defined in R.S. 40:2133(A)

2. Billing Audit - a process to determine whether data in a providers medical record documents or supports services listed on a hospital bill. Billing audit does not mean a review of medical necessity of services

provided, cost or pricing policy of a facility and adjustments for the medical reimbursement schedule.

3. Health Record Which Shall Mean Medical Record - any compilation of charts, records, reports, documents and other memoranda prepared by a health care provider, wherever located to record or indicate the past or present condition, injury or disease and treatment rendered, physical or mental of a patient.

4. Historic Error Rate - the average error found during all audits conducted by external qualified billing auditors during the preceding calendar year. It shall be calculated by totaling the net adjustments made to all accounts audited by external qualified billing auditors during that year and dividing that total by the total amount claimed by the audited party to be due on those accounts immediately preceding the audit. This calculation results in an average rate for all externally audited cases expressed as a percentage.

5. Hospital - hospital as defined in R.S. 40:2102(A).

6. Patient - a natural person who receives or should have received health care from a health care provider, under a contract expressed or implied.

7. Qualified billing auditor - a person employed by a corporation or firm that is recognized as competent to perform or coordinate billing audits and that has explicit policies and procedures protecting the confidentially of all the patient information in their possession and disposal of this information.

8. Unbilled Charges - the volume of services indicated on a bill is less than the volume identified in a provider's health record documentation; also known as undercharges.

9. Unsupported or Undocumented Charges - the volume of services indicated on a bill exceeds the total volume identified in a provider's health record documentation; also known as overcharges.

C. Qualifications of Auditors and Audit Coordinators

All persons performing billing audits as well as persons functioning as the hospital audit coordinators shall have appropriate knowledge, experience and/or expertise in a number of areas of health care including, but not limited to the following areas:

1. format and content of the health record as well as other forms of medical/clinical documentation;

2. generally accepted auditing principles and practices as they may apply to billing audits;

3. billing claim forms, including the UB82 and UB92, the HCFA 1500 and charging and billing procedures;

4. all state and federal regulations concerning the use, disclosure, and confidentiality of all patient records; and

5. specific critical care units, specialty areas, and/or ancillary units involved in a particular audit.

Hospitals or Carrier/Self Insured Employer, audit personnel who do not meet these qualifications shall immediately contact the auditors firm or sponsoring party, but may not request information unrelated to the area listed above.

Audit personnel shall be able to work with a variety of health care personnel and patients. They shall always conduct themselves in an acceptable, professional manner and adhere to ethical standards, confidentiality requirements and objectivity. They shall completely document their findings and problems.

All unsupported or unbilled charges identified in the course of an audit must be documented in the audit report by the auditor. Individual audit personnel shall not be placed in a situation through their remunerations, benefits, contingency fees or other instructions that would call their findings into question. In other words, compensation of audit personnel shall be structured so that it does not create any incentives to produce questionable audit findings. Hospital or Carrier/Self-Insured Employers who encounter an individual who appears to be involved in a conflict of interest shall contact the appropriate management of the sponsoring organization.

D. Notification of Audit

Hospitals and Carrier/Self Insured Employers shall make every effort to resolve billing inquiries directly. To support this process, the name and contact telephone number (and/or facsimile number) of each Carrier/Self Insured Employer or hospital representative shall be exchanged no later than the time of billing for a hospital and the point of first inquiry by a Carrier/Self Insured Employer.

If a satisfactory resolution of the questions surrounding the bill is not achieved by Carrier/Self Insured Employer and hospital representatives, then a full audit process may be initiated by the Carrier/Self Insured Employer.

Generally, billing audits require documentation from or review of a patient's health record and other similar medical/clinical documentation. Health records exist primarily to ensure continuity of care for a patient; therefore, the use of a patient's record for an audit must be secondary to its use in patient care.

To alleviate the potential conflict with clinical uses of the health record and to reduce the cost of conducting a necessary audit, all Carrier/Self Insured Employer billing audits shall begin with a notification to the hospital of an intent to audit. Notification of the hospital by the qualified billing auditor shall occur no later than four months following

receipt of the final bill by the Carrier/Self Insured Employer. Once notified, the hospital shall respond to the qualified billing auditor within one month with a schedule for the conduct of the audit. The qualified billing auditor shall complete the audit within six months of receipt of the final bill by the Carrier/Self Insured Employer. When there is a substantial and continuing relationship between a Carrier/Self Insured Employer and a hospital, this relationship may warrant a notification, response, and audit schedule other than that outlined herein. Also, each party shall make reasonable provisions to accommodate circumstances in which the schedule specified herein cannot be met by the other party.

All billing audits shall be conducted "on site".

All requests, whether telephonically or written, for billing audits shall include the following information:

1. the basis of the Carrier/Self Insured Employer's intent to conduct an audit on a particular bill or group of bills (when the intent is to audit only specific charges or portions of the bill, this information should be included in the notification request);

2. name of the patient;

3. admit and discharge dates;

4. name of the auditor and the name of the audit firm;

5. medical record number and hospital's patient account number; and

6. whom to contact at the Carrier/Self Insured Employer institution and, if applicable, at the agent institution to discuss this request and schedule the audit.

Hospitals who cannot accommodate an audit request that conforms with these guidelines shall explain why the request cannot be met by the hospital in a reasonable period of time. Auditors shall group audits to increase efficiency whenever possible.

If a hospital believes an auditor will have problems accessing records, the hospital shall notify the auditor prior to the scheduled date of audit. Hospitals shall supply the auditor/Carrier/Self Insured Employer with any information that could affect the efficiency of the audit once the auditor is on-site.

E. Hospital Audit Coordinators

Hospitals shall designate an individual to coordinate all billing audit activities. An audit coordinator shall have the same qualifications as an auditor. Duties of an audit coordinator include, but are not limited to the coordination of the following areas:

1. scheduling an audit;

2. advising other hospital personnel, departments of a pending audit;

3. ensure that the condition of admission is part of the medical record;

4. verifying that the auditor is an authorized representative of the payer;

5. gathering the necessary documents for the audit;

6. coordinating auditor requests for information, space in which to conduct an audit and access to records and hospital personnel;

7. orienting auditors to hospital audit procedures, record documentation conventions and billing practices;

8. acting as a liaison between the auditor and other hospital personnel;

9. conducting an exit interview with the auditor to answer questions and review audit findings;

10. reviewing the auditor's final written report and following up on any charges still in dispute.

11. arranging for payment as applicable; and

12. arranging for any required adjustment to bills or refunds.

F. Conditions and Scheduling of Audits

In order to have a fair efficient and effective audit process, hospitals and Carrier/Self Insured Employer auditors shall adhere to the following requirements:

1. whatever the original intended purpose of the billing audit, all parties shall agree to recognize, record or present any identified unsupported or unbilled charges discovered by the audit parties;

2. late billing shall not be precluded by the scheduling of an audit;

3. the parties involved in the audit shall mutually agree to set and adhere to a predetermined time-frame for the resolution of any discrepancies, questions or errors that surface in the audit;

4. an exit conference and a written report shall be part of each audit; if the hospital waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit.

5. if the hospital decides to contest the findings, the auditor shall

be informed immediately.

6. once both parties agree to the audit findings, audit results are final;

7. all personnel involved shall maintain a professional courteous manner and resolve all misunderstandings amicably; and

8. at times, the audit will note ongoing problems either with the billing or documentation process. When this situation occurs, and it cannot be corrected as part of the exit process the management of the hospital or Carrier/Self Insured Employer organization shall be contacted to identify the situation and take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate on-going problems or questions whenever possible as part of the audit process.

G. Confidentiality and Authorization

All parties to a billing audit shall comply with all federal and state laws and any contractual agreements regarding the confidentiality of patient information.

The release of medical records may require authorization from the patient. Such authorization shall be provided for in the condition of admission or equivalent statement procured by the hospital or ambulatory surgical center upon admission of the patient. If no such statement is obtained, an authorization for a billing audit shall be required. Authorization need not be specific to the Carrier/Self Insured Employer or auditor conducting the audit.

Each authorization shall be obtained by the billing audit firm or Carrier/Self Insured Employer and shall include:

1. the name of the Carrier/Self Insured Employer and if applicable, the name of the audit firm that is to receive the information;

2. the name of the institution that is to release the information;

3. the full name, birthdate and address of the patient whose records are to be released;

4. the extent or nature of the information to be released, with inclusive date of treatment;

5. the hospital's patient account number; and

6. the signature of the patient or his legal representative and the date the consent is signed.

A patient's assignment of benefits shall include a presumption of authorization to review records.

The audit coordinator or medical records representative shall confirm for the audit representative that a condition of admission statement is available for the particular audit that needs scheduling.

The hospital will inform the requestor, on a timely basis, if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedure affecting the review. These institutional confidentiality policies shall not be specifically oriented in order to delay an external audit.

H. Documentation

Verification of charges will include the investigation of whether or not:

1. charges are reported on the bill accurately;

2. services are documented in health or other appropriate records as having been rendered to the patient; and

3. services were delivered by the institution in compliance with the physician's plan of treatment. (In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established institutional policies, procedures, or professional licensure standards. Many procedures include items that are not specifically documented in a record but are referenced in medical or clinical policies. All such policies should be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Healthcare Organizations or other accreditation of healthcare organizations or other accreditation agencies. Policies should be available for review by the auditor.)

The health record documents clinical data on diagnoses, treatments, and outcomes. It was not designed to be a billing document. A patient health record generally documents pertinent information related to care. The health record may not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the provider's ancillary departments in the form of department treatment logs, daily records, individual service/order tickets, and other documents.

Auditors may have to review a number of other documents to determine valid charges. Auditors must recognize that these sources of information are accepted as reasonable evidence that the services ordered by the physician were actually provided to the patient. Hospitals must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the health record and in the ancillary records and/or logs. These procedures document that services have been properly ordered for and delivered to patients. When sources other than the health record are providing such documentation, the hospital shall notify the auditor and make those sources available to the auditor.

I. Fees and Payment

Payment of a bill shall be made promptly and shall not be delayed by an audit process. Payment on a submitted bill shall be based on amount billed and covered charges pursuant to the Louisiana Workers' Compensation reimbursement schedules.

Billing audits shall be made in accordance with one of the following three audit fee and payment schedules:

1. a $100.00 audit fee shall be paid by the auditor to the audited party. Such audited party shall not require payment greater than 100 percent of the audited party's submitted bill minus such party's historic error rate;

2. in those instances where the audited party has had less than 12 audits in a calendar year, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be seven percent; and

3. the $100.00 fee shall be waived in the following scenarios:

a) payment of 100 percent of the covered charges has been made.

b) the on-site audit commencement date exceeds 60 days from the date of the request for audit; or

c) audit fees are not required or are otherwise being waived.

Each hospital's billing audit coordinator shall maintain a log containing the results of all audits performed by external qualified billing auditors in the preceding 24 months. In cases where the log is not complete for the past 24 months, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be seven percent.

The audit log shall contain the amount billed immediately preceding the audit, and net adjustments resulting from the audit, the name, address, and phone number of the audit firm conducting the audit, and the name of the qualified billing auditor who performed the audit. Audits whose results are in dispute and audits ordered by the hospital and conducted by its own or contracted audit organization shall not be included in the audit log. The audit log shall be available at all times during regular business hours for inspection by any qualified billing auditor.

Audit fees, if needed, are to be paid upon commencement of the on-site billing audit. Any payment identified in the audit results, that is owed to either party by the other, shall be settled by the audit parties within a reasonable period of time - not to exceed 30 days after completion of the audit unless the two parties agree otherwise.

Neither the hospital nor the qualified billing auditor shall require a billing, or re-billing, or refund request following final audit determination,

but all findings shall be netted and the final result will be due by the relevant party without additional billing.

Photocopying and duplication charges shall be paid at the following rates:

1. $1.00 per page for the first 25 pages;

2. $ .50 per page for 26-500 pages;

3. $. 25 per page thereafter;

4. handling charge not to exceed $10.00 for hospitals and $5.00 for other health care providers; and

5. actual postage charge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated on Emergency Rule by Louisiana Department of Employment & Training, Office of Workers' Compensation, L.R. 16:387, (Oct. 1990). Repromulgated by L.R. 17:653, July 1991; L.R. September 1991.